Tamar K. Gottfried, M.D. PLC

Request for Access to EHR (Electronic Health Records)

Patient Name: _____ Patient ID#: 1006

I hereby request Tamar K. Gottfried, M.D. PLC to:

___ Send me a copy of my electronic health record to:

_____

X Send a copy of my electronic health record to the following third parties:

a. Name: _____

b. Address: _____

c. _____

d. Phone #: _____ fax #: _____

And I understand that there is a nominal fee associated with the request which is:

Calculated fee for forwarding electronic health records: ∅

which covers the cost of forwarding the aforementioned records. I also understand that I may be required to pay the fee in full before the request can be fulfilled.

I further understand that:

1) Tamar K. Gottfried, M.D. PLC maintains electronic health records that contain protected health information about me as a patient, such as medical and billing records, and records that are used, in whole or in part, to make decisions about me, my treatment, or billing for services rendered.
2) I have the right to inspect and obtain a copy of my above mentioned electronic health records maintained by Tamar K. Gottfried, M.D. PLC.
3) My request must be made in writing using this form, which must be completed prior to Tamar K. Gottfried, M.D. PLC providing me with the requested information.
4) If I request Tamar K. Gottfried, M.D. PLC to forward my electronic health record, they have the right to charge me for forwarding the requested information to me or a third party that I designate.
5) I have the right to request an amendment to my protected health information mentioned above.
6) Within 30 days (60 days if information is not maintained or accessible on-site), I will receive a response from Tamar K. Gottfried, M.D. PLC indicating whether my request for access has been accepted or denied, or a notification that they require an additional 30 days to consider my request. If they require an extension, they will explain the reason for the delay and the date by which they will make a decision. If they deny my request, they will inform me in writing of the reason for the denial, and instruct me on how I can go about disputing a denial or filing a complaint.

X _____ X _____

Signature of Patient or Legal Representative **Date**

X _____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Request ☐ Accepted ☐ Denied

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Reason for Denial (*if applicable*)
- ☐ Access is likely to endanger the life or physical safety of the individual or another person
- ☐ Psychotherapy notes
- ☐ The information is compiled for use in a civil, criminal, or administrative action or proceeding
- ☐ Other (*full list of other reasons for possible denial at 45 CFR §164.524(a)(1)-(3)*):

Date Request Received _____ **Received By** _____

Date Request Fulfilled _____ **Fulfilled By** _____

Extension Requested ____Yes ____No **Date Patient Notified in Writing of Extension** _____

If Extension Requested, Give Reason _____